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PROVIDER BULLETIN

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PSYCHOTHERAPY BULLETIN

PHYSICIAN (PSYCHIATRIST), PSYCHOLOGIST, PCNS, LCSW, LPC, FQHC, RHC

CONTENTS

PRIOR AUTHORIZATION FOR CHILDREN IN STATE CUSTODY – FOSTER CARE *(ME CODE 07, 08, 37, AND 38)*

The MO HealthNet Division (MHD) will implement Prior Authorization (PA) of psychological services on January 2, 2008 for foster children in state custody and for former foster children through age 20 who were in foster care on their 18th birthday.

Children are best treated within the context of the environment in which they live. Children thrive within families and, therefore, treatment should support the child within the family context whenever possible. Clinical evidence suggests that family intervention is superior to individual therapy in treating children with many psychological disorders. Clinical evidence also suggests that treatment must be determined based upon the age (and thus, cognitive development) of the child. Should multiple providers be involved with the same child or family, Best Practice approaches insure the coordination of care.

The PA process for psychological services (13 CSR 70-98.020) serves as a utilization management measure allowing payment for treatment and services (interventions) that are

medically necessary, appropriate and cost-effective without compromising the quality of care to MO HealthNet participants.

The PA requirement process includes psychological services provided by a psychiatrist, psychologist or provisionally licensed psychologist, psychiatric clinical nurse specialist (PCNS), licensed clinical social worker (LCSW), provisionally licensed clinical social worker (PLCSW), licensed professional counselor (LPC), provisionally licensed professional counselor (PLPC), rural health clinic (RHC), and federally qualified health clinic (FQHC).

START DATE FOR PRIOR AUTHORIZATION FOR CHILDREN IN FOSTER CARE (ME CODES 07, 08, 37, AND 38)

Effective January 2, 2008, MHD will implement the PA process for children birth (0) through 20 who are in foster care or were in foster care on their 18th birthday. This includes the MO HealthNet Eligibility Codes 07, 08, 37 and 38 who are in the Legal Custody of the Children's Division. This also does **not** apply to services provided to children in residential care.

Beginning immediately, PAs may be requested via telephone. The provider or a staff member may place the call but the Psychological Services Request for Prior Authorization form, although not mandatory, should be completed as the information on this form is required to complete the request for services. Telephoned requests receive an approval or denial at the time of the call. If additional information is needed the caller is instructed to fax or mail the Psychological Services Request for Prior Authorization form and required documentation. This PA request is not approved during the phone call. PA of psychological services for children is based on the age of the child and the type of therapy requested. Based on these guidelines the first request for PA may include Individual, Family, and Group Therapy.

Assessment and Testing for a child under the age of 3 must be prior authorized and providers must submit clinical justification for providing these services. Prior authorization does not allow the provider to exceed the unit limitations for these services.

Requests may be made as follows:

Mail: MO HealthNet Division
P.O. Box 4800
Jefferson City, MO 65102
Or
Phone: 866-771-3350
Or
Fax: 573-635-6516

The Psychological Services Request for Prior Authorization form must be used when requesting a PA by mail or by fax. If requesting continued treatment, the Psychological

Services Request for Prior Authorization form must be mailed or faxed and accompanied by the:

• Current Diagnostic Assessment
• Current/Updated Treatment Plan
• Last three Progress Notes reflective of therapy type being requested (i.e. requests for additional family therapy should include, progress notes from the three most recent Family Therapy sessions attended by the patient).

INITIAL FOUR HOURS OF PRIOR AUTHORIZED SERVICES

For dates of service January 2, 2008 and after the first four (4) hours of psychological services do not require PA. *The first four (4) hours will be allowed per provider, per participant, per rolling year. If more than the four (4) non-PA'd hours are needed a PA must be obtained. This PA must be requested prior to rendering the services. In order to insure continuity of services providers should request a PA before all of the first four (4) hours are used.*

The first four (4) hours are intended to assist a provider **seeing a patient for the first time** in making the transition to PA should more than four (4) hours be required for treatment. The provider may use these hours in time segments according to procedure code and policy requirements. The **claims** for the four (4) non-PA hours should be submitted and payment received prior to submitting claims for any PA hours/services. **Family Therapy without the Patient Present, Individual Interactive Therapy and all psychological services for patients age birth through 2 years are not included in the four (4) non-PA'd hours and continue to require PA.**

PRIOR AUTHORIZAITON EXEMPTIONS

Procedure codes with a medical Evaluation and Management service component, Inpatient Hospital services, Pharmacologic Management, Narcosynthesis and Electroconvulsive Therapy are exempt from PA.

Crisis Intervention, when provided by a psychiatrist, psychologist, provisionally licensed psychologist, PCNS, LCSW, PLCSW, LPC, PLPC, RHC and FQHC are exempt from the PA process. The definition of Crisis Intervention is: "the situation must be of significant severity to pose a threat to the patient's well being or is a danger to self or others". Crisis Intervention services cannot be scheduled nor can they be PA'd.

RESIDENTIAL CARE EXEMPTIONS

Services provided in the residential treatment facility setting will be exempt from the PA Process. Services provided in residential treatment facilities are identified by the following place of service codes: 14 – group home, 33 – custodial care facility and 56 – psychiatric residential treatment center. Services provided to children in these settings will not require a PA.

NOTE: **Family Therapy without the Patient Present, Individual Interactive Therapy and all psychological services for patients age birth through 2 years continue to require PA, regardless of child's placement.**

PRIOR AUTHORIZATION HOURS

PAs for psychological services for children are issued for a maximum of ten (10) hours for Adjustment Disorder, V-code, or NOS DSM-IV-TR diagnosis codes.

MO HealthNet Division (MHD) recognizes there are rare instances where Psychological services may be needed beyond the guidelines outlined above. For those persons requiring more therapy than what is allowed under the above guidelines, Clinical Exceptions may be granted based upon documentation of extenuating circumstances. Providers requesting Clinical Exceptions may contact the Psychology Help Desk at (866)771-3350.

For the hours issued for all other covered diagnosis codes refer to the PA guidelines by age groups that follow. Providers are urged to choose the most accurate and most appropriate diagnosis code in order to receive the maximum hours allowed through the PA process.

PRIOR AUTHORIZATION GUIDELINES BY AGE GROUP AND HOURS ASSIGNED

***0 – 2 YEAR OLDS** --- ALL REQUIRE PA/CLINICAL REVIEW

- 10 Family Therapy (FT) with clinical review
- 20 reauthorization with clinical review
- 20 reauthorization with clinical review

***3 YEAR OLDS**

- 10 FT without (w/o) submitting documentation
- 15 FT reauthorization with documentation
- 15 FT reauthorization with documentation

- 5 Individual Therapy (IT) OR 5 Individual Interactive Therapy (IIT) with clinical review
- 10 IT OR 10 IIT reauthorization with clinical review

- Group therapy (GT) is not allowed for this age group

MO HealthNet Division (MHD) recognizes there are rare instances where Psychological services may be needed beyond the guidelines outlined above. For those persons requiring more therapy than what is allowed under the above guidelines, Clinical Exceptions may be granted based upon documentation of extenuating circumstances. Providers requesting Clinical Exceptions may contact the Psychology Help Desk at (866)771-3350.

***4 YEAR OLDS**

- 10 FT w/o submitting documentation
- 15 FT reauthorization with documentation

- 15 FT reauthorization with documentation

- 5 IIT clinical review with required documentation
- 15 IIT reauthorization with documentation
- 15 IIT reauthorization with documentation OR

- 5 IT w/o documentation (if appropriate for Insight Oriented Psychotherapy)
- 15 IT reauthorization with documentation
- 15 IT reauthorization with documentation

- Group therapy is not allowed for 4 year olds.

MHD recognizes there are rare instances where Psychological services may be needed beyond the limits outlined above. For those persons requiring more therapy than what is allowed under the above guidelines, Clinical Exceptions may be granted based upon documentation of extenuating circumstances. Providers requesting Clinical Exceptions may contact the Psychology Help Desk at (866)771-3350.

***5-20 YEAR OLDS**

- 10 FT w/o submitting documentation
- 15 FT reauthorization with documentation
- 15 FT reauthorization with documentation

- 10 IT w/o documentation
- 15 IT reauthorization with documentation
- 15 IT reauthorization with documentation

- 10 GT w/o documentation
- 15 GT reauthorization with documentation
- 15 GT reauthorization with documentation

MHD recognizes there are rare instances where Psychological services may be needed beyond the guidelines outlined above. For those persons requiring more therapy than what is allowed under the above guidelines, Clinical Exceptions may be granted based upon documentation of extenuating circumstances. Providers requesting Clinical Exceptions may contact the Psychology Help Desk at (866) 771-3350.

REQUESTING ADDITIONAL HOURS/REAUTHORIZATION

To request continuing services after the initial PA, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the current/updated Treatment Plan, current Diagnostic Assessment and copies of the last three Progress Notes. If the services being requested are court ordered, a copy of the court order must also be attached.

If the current PA was approved for less than 10 hours, additional hours may be requested when 40% of the current PA hours have been used. If the current PA was approved for 10 hours or more, 75% of the current PA hours must be used before additional hours may be requested. Hours used must be documented in the medical record. When requesting an authorization for additional hours, the documentation must include information from the most recent contacts available for review.

PRIOR AUTHORIZATION AGE CHANGES

If a child's age changes during the PA period, the PA will continue as authorized. However, please be advised that if the child reaches age 21 during the authorization period, those providers restricted to services provided to patients ages 20 and under will not be paid for those services performed on or after the date the child reaches the age of 21 even if PAd. The policy for age restrictions for certain provider specialties will still apply.

PRIOR AUTHORIZATION CHANGES/CLOSES

If the patient is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the patient, or the patient's guardian, requesting a change in provider, in order to close the current PA. The signed release must include the client DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed. If Continued Treatment is required (and the initial provider utilized hours authorized) *the new provider must forward the Psychological Services Request for Prior Authorization form, current Assessment, current Treatment Plan, and Progress Notes to the Psychology Help Desk to request a transfer of PA.*

If a provider needs to **change** a PA, the provider may call or fax in the information to request a change. The patient's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

When a patient changes providers any available units are transferred from the closed PA to the new provider's approved PA if requested. The new provider does not receive an additional 10 hours for therapy, or additional hours above the established guidelines outlined in this bulletin. However, clinical exceptions may be granted based upon documentation of extenuating circumstances. A patient may have an open PA with one provider for Individual Therapy and/or Family Therapy and a second PA open with the same or different provider for Group Therapy.

CLINICAL EXCEPTIONS

The MHD recognizes that there are rare instances in which Psychological services may be required beyond the guidelines outlined above. For those patients who require additional therapy, a Clinical Exception may be requested based upon documentation of extenuating circumstances. Providers may contact the Psychology Help Desk (866-771-3350) for additional information on requesting a Clinical Exception.

Regardless of PA, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly and yearly limits represent a violation of MHD policy and are not reimbursed.

PSYCHOLOGICAL DIAGNOSIS CODING

Psychological services will be covered if they are determined medically necessary when using the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV-Text Revision) or most recent update. In order to maintain compliant with the Health Insurance Portability and Accountability Act (HIPAA), the appropriate International Classification of Diseases –Ninth Edition (ICD-9) diagnosis code must be used when filing a claim for the service. Please refer to section 18.3 of the Psychology/Counseling Manual.

PSYCHOTHERAPY DEFINITIONS

Documentation for the following services must meet the requirements as stated in (13 CSR 70-98.015) http://www.sos.mo.gov/adrules/csr/current/13csr/13c70-98.pdf and further defined in policy.

Individual Therapy:
Individual Therapy must consist of a medically necessary, time-limited, goal-specific face-to-face interaction, which results from a planned intervention documented in the Treatment Plan developed in response to the issues identified in the Diagnostic Assessment. **Providers should note that this therapy is defined as Insight Oriented and is NOT appropriate for very young children**. Progress Notes must be written in narrative form, fully describing each session billed. Progress notes shall be maintained in the patient's medical record for each date of service, be legible, and document date of service, presenting issues related to Diagnosis and Treatment Plan, therapist intervention, patient progress toward goals and plan etc..

Individual Interactive Therapy:
Individual Interactive Therapy is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and the patient who has not yet developed, or has lost, either the expressive language communication skills to explain his or her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Family Therapy:
Family Therapy focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family Therapy is provided within a time-limited, goal-specific, face-to-face interaction based upon planned intervention documented in the Treatment Plan developed in response to the issues identified in the Diagnostic Assessment. Each member of the family included in the session must be identified with first and last name. Progress Notes document the immediate issue addressed

in therapy, description of therapist intervention and patient progress toward established goals. At least 75% of the session must have both the parent and the child present. Only one family therapy session may be billed per family per day and each child may **not** be seen separately with parents and billed as Family Therapy.

Only one (1) PA will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN *must* be used for PA and billing purposes. When a specific child is identified as the primary patient of treatment, that child's DCN *must* be used for PA and billing purposes. Providers should ***not*** request more than one (1) Family Therapy PA per family.

The definition of a "family" may be biological, foster, adoptive or other family unit. **A family is *not* a group and providers may *not* submit a claim for each eligible person attending the same Family Therapy session. At least 75% of the session *must* have both child/children and parent(s) present.**

Family Therapy without Patient Present:
Family Therapy without the Patient Present (90846) requires PA regardless of the age and is not allowed under the four hours of non-PAd services. All requests for Family Therapy without the Patient Present will be authorized based upon the submission of required documentation and subsequent clinical review.

Family Therapy without the Patient Present focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family Therapy without the identified patient present is provided within a time-limited, goal-specific, face-to-face interaction based upon planned intervention documented in the Treatment Plan developed in response to the issues identified in the Diagnostic Assessment. Each member of the family included in the session must be identified with first and last name. Progress Notes document the immediate issue addressed in therapy, description of therapist's intervention and progress toward established goals. Family Therapy without the Patient Present must be provided with the services focused specifically toward that identified patient. **NOTE: This therapy is directed toward the needs of the patient and not the parent. Parents requiring Individual Therapy should obtain services under their own eligibility. It is a violation of MHD policy for Providers to bill services on behalf of adults under the child's DCN and may result in recoupment.**

Group Therapy:
Group Therapy uses the power of group dynamics and peer interactions to increase understanding and improve social skills. Groups are medically necessary, time-limited, goal-specific face-to-face interactions based upon planned intervention documented in the Treatment Plan developed in response to the issues identified in the Diagnostic Assessment. Groups are limited in size to three (3) but no more than ten (10) patients. Progress Notes document the number of group members present, description of immediate issues addressed

in therapy, identification of underlying roles, conflicts or patterns, a description of therapist intervention and, patient progress toward individual goals.

ADEQUATE DOCUMENTATION

Psychology counseling services under MO HealthNet have specific documentation requirements as noted in the Code of State Regulations, 13 CSR 70-98.015.

Reimbursement for each date of service must contain the following documentation in the patient's medical record.

- This documentation must be in narrative form fully describing each session billed.
- A check-off list or pre-established form is not accepted as sole documentation.

Providers are reminded to review the Code of State Regulations, 13 CSR 70-030 (3) (A) 38 which states: "… documentation which is to be made contemporaneously to the date of service" and the word contemporaneous is defined in 13 CSR 70-3.030 (2) (d) as "Contemporaneous means at the time the service was performed or within seventy-two (72) hours of the time the service was provided". **THESE DOCUMENTATION REQUIREMENTS APPLY WHETHER OR NOT THE DOCUMENTATION IS SUBMITTED FOR REVIEW.**

Sample documentation will be available at Provider Training and on MO HealthNet's Web site. Providers may view a sample of an Assessment, an updated Assessment, a Treatment Plan, a Treatment Plan update, and sample Progress Notes for Individual and Family Therapy services. These documents are samples only and MO HealthNet does not require a specific format. However, these documents demonstrate the content that is required based on policy and the Code of State Regulations stated above and can be used as a guideline.

Diagnostic Assessment

A Diagnostic Assessment from a MO HealthNet enrolled provider shall be documented in the patient's medical record. The Diagnostic Assessment shall assist in ensuring an appropriate level of care, identifying necessary services, developing an individualized Treatment Plan, and documenting the following:

A. Statement of needs, goals, and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;

B. Presenting situations/problem and referral source;

C. History of previous psychiatric and/or substance abuse treatment including number and type of admissions; documentation of prior/current counseling including date range, purpose, duration and provider;

D. Current medications and identifications of any medication allergies and adverse reactions;

E. Recent alcohol and drug use for at least the past 30 days and, when indicated, a substance abuse history that includes duration, patterns, and consequences of use;

F. Current psychiatric symptoms. These current symptoms must address the diagnostic criteria in support of the diagnosis being made.

G. Family, social, legal, and vocational/educational status and functioning. The collection and assessment of historical data is also required unless short-term crisis intervention or detoxification is the only services being provided;
H. Current use of resources and services from other community agencies;
I. Personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports; and
J. Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD9-CM). The ICD9-CM is required on the Treatment Plan for billing purposes.

The Diagnostic Assessment must be signed and dated by the provider delivering the service. The date should reflect the date the service was provided. If the Diagnostic Assessment was completed over a span of days each portion of the Diagnostic Assessment should reflect the date that portion of the service was delivered with the date at the end of the form reflecting the date the entire Diagnostic Assessment was completed. The dates billed should reflect the dates each portion was delivered.

A Diagnostic Assessment should result in a determination that no further services are required or should be used in developing an individualized Treatment Plan. The Diagnostic Assessment must be current – within one year for adults and adolescents (age 13 to 20) or six months for children under 13.

An update to the Diagnostic Assessment is required in occurrence of a crisis or significant clinical event.

Plan of Treatment Documentation

A plan of treatment is a required document in the overall record of the patient. A Treatment Plan must be developed by the provider based on a Diagnostic Assessment that includes:

- Examination of the medical, psychological, social, behavioral, and developmental aspects of the patient's situation and reflects the need for psychology/counseling services. The Treatment Plan shall be individualized to reflect the patient's unique needs and goals. The plan shall include, but is not limited to, the following:

A. Measurable goals and outcomes;
B. Services, support, and actions to accomplish each goal/outcome. This includes services and supports and the staff member responsible, as well as action steps of the patient and other supports (family, social, peer and other natural supports);
C. Involvement of family, when indicated;
D. Identification of other agencies working with the patient, plans for coordinating with other agencies, or identification of medications, which have been prescribed, where applicable;
E. Services needed beyond the scope of the organization or program that are being addressed by referral or services at another community organization, where applicable;
F. Projected time frame for the completion of each goal/outcome not to exceed 12 months; and
G. Estimated completion/discharge date for the level of care.

Documentation required by MO HealthNet does not replace or negate documentation/reports required by the Children's Division for individuals in their care or custody. Providers are expected to comply with policies and procedures established by the Children's Division and MHD.

The Treatment Plan must be signed and dated by the provider delivering the service.

The Treatment Plan must be current – within one year for adults and adolescents (age 13 to 20) or six months for children under 13.

An update to the Treatment Plan is required in the occurrence of a crisis or significant clinical event.

Progress Notes

Progress Notes for psychology/counseling services shall be written and maintained in the patient's medical record for each date of service for which a claim is filed. Progress Notes shall specify:

- First and last name of patient;

When family therapy is furnished:

- Each member of the family included in the session must be identified. (The family unit is viewed as a social system that affects all its members. A parent must be present 75% of the time to be billed as family therapy.
- The description of immediate issue addressed in therapy.
- Identification of underlying roles, conflicts or patterns,
- Description of therapist intervention must also be identified.

When group therapy is furnished:

- Each service shall include the number of group members present. (Minimum of three but no more than 10 patients)
- Description of the immediate issue addressed in therapy, identification of underlying roles, conflicts or patterns.
- Description of therapist intervention and progress towards goals.

When interactive therapy is furnished:

- Documentation of the need for service;
- Describe the type of equipment, devices or other mechanisms used;
- The specific service(s) rendered including the Procedure Code;
- Name of person who provided the service;
- The date (month/date/year) and the actual begin and end time (e.g., 4:00-4:30 p.m. the face-to-face services;
- The setting in which the service was rendered;
- The patient's report of recent symptoms and behaviors related to their diagnosis and Treatment Plan goals;
- The therapist interventions for that visit and patient's response;
- The pertinence of the service to the Treatment Plan; and
- The patient's progress toward one or more goals stated in the Treatment Plan.
- The progress note must be signed and dated by the provider delivering the service.

- The progress note must document the specific service delivered. The service must be a covered service as defined in Section 13.17 to be billed to MO HealthNet.

NOTE: The MO HealthNet enrolled provider is the only person who can provide psychology/counseling services and be reimbursed for these services. Services provided by someone other than the enrolled provider are not covered by MO HealthNet and may not be billed to MO HealthNet by or on behalf of another individual. Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

Plan of Treatment Review

The Treatment Plan shall be reviewed on a periodic basis to evaluate progress towards treatment goals and outcomes and to update the plan.

- Each person shall directly participate in the review of his or her individualized Treatment Plan.
- The frequency of Treatment Plan reviews shall be based upon the individual's level of care or other applicable program rules. The occurrence of a crisis or significant clinical event may require further review and modification of the Treatment Plan.
- The individualized Treatment Plan shall be updated and changed as indicated.
- Each Treatment Plan update shall include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress to treatment goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications.
- The therapist's plan for continuing treatment and/or termination from therapy and aftercare shall be considerations expressed in each Treatment Plan update.

The Treatment Plan update must be signed and dated by the provider delivering the service. The Treatment Plan update must be current – within one year for adults and adolescents (age 13 to 20) or six months for children under 13. An update to the Treatment Plan would be necessary in the occurrence of a crisis or significant clinical event.

Aftercare Plan

When care is completed, the Aftercare Plan shall include, but is not limited to, the following:

- Dates begin and end;
- Frequency and duration of visits;
- Target symptoms/behaviors addressed;
- Interventions;
- Progress to goals achieved;
- Final diagnosis; and
- Final recommendations including further services and providers, if needed, and activities to promote further recovery.

For all medically necessary covered services, a writing of all stipulated documentation elements referenced in this section is an essential and integral part of the service itself. No service has been performed if documentation requirements are not met. No service is reimbursed if documentation requirements are not met.

The Aftercare Plan must be signed and dated by the provider delivering the service.

PARTICIPANT APPEAL RIGHTS

When a request is denied, the participant will receive a letter which outlines the reason for the denial and the procedure for appeal. The State Fair Hearings Process may be requested by the participant, in writing, to MHD, Participant Services Unit (PSU), P.O. Box 3535, Jefferson City, MO 65102-3535. The Participant Services Unit may also be called toll free at 1-800-392-2161 or 573-751-6527 at the caller's expense. The participant must contact PSU within 90 days of the date of the denial letter if they wish to request a hearing. After 90 days, requests to appeal are denied.

HELPFUL WEB SITE LINKS

The following links will be helpful for providers when completing the PA process.

• CHILDREN'S GLOBAL ASSESSMENT SCALE (C-GAS) SCORING GUIDELINES
• MODIFIED GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF SCALE) SCORING GUIDELINES

Providers may also find a link to information regarding Diagnostic Classification of Mental Health And Development Disorders Of Infancy and Early Childhood: DC:0-3R, which is appropriate for 0 to 3 year olds. MO HealthNet does not require providers to use this tool but the information can be helpful and may be purchased at the provider's discretion.

rovider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at http://dss.mo.gov/mhd/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Website at http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via e-mail.

Mo HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896